Behavioral Health Coordinating Council Meeting Minutes

JUNE 26, 2013 10:05 AM BOARD ROOM 24-260

MEETING CALLED BY	Commissioner Frank Berry at 10:05 AM
FACILITATOR	Commissioner Frank Berry
MINUTE TAKER	Stephanie McGruder
COUNCIL ATTENDEES PRESENT	Frank Berry, David Cook, Stanley Jones, Brian Owens, Clyde Reese and Renee Unterman

AGENDA

CALL TO ORDER	COMMISSIONER FRANK BERRY
DISCUSSION	Commissioner Frank Berry welcomed everyone and introduced Russell Crutchfield who was attending on behalf of Commissioner Brenda Fitzgerald, DPH and Terry Bernard who was attending on behalf of Chairman Albert Murray, PAP.
PRESENTATION	MARK BAKER, DBHDD DIRECTOR OF RECOVERY TRANSFORMATION
DISCUSSION	Mark Baker introduced RESPECT Institute graduate and guest speaker, Ms. Florence Daniels. Ms. Daniels shared her early family life and traumatic experiences while serving in the military. These experiences led to a diagnosis of Post Traumatic Stress Disorder (PTSD) and involvement with the legal system. Ms. Daniels is now living a life of recovery and is currently employed by the Veterans Administration (VA) where she provides support to veterans living with mental illness. She is a member of the Georgia Mental Health Consumer Network GMHCN, a Certified Peer Support Specialist and she is committed to helping others by sharing her experiences.
CONCLUSIONS	There was no discussion or action taken.
ACTION ITEMS	
APPROVAL OF MINUTES	COMMISSIONER FRANK BERRY
DISCUSSION	Commissioner Frank Berry informed the Coordinating Council that there was not a quorum present to approve the March 27, 2013 BHCC Meeting minutes.
CONCLUSIONS	The March 27, 2013 minutes will be approved at the September 25th BHCC meeting.

Commissioner Frank Berry stated that at the March meeting, the BHCC charged a workgroup to explore interagency barriers and formulate a plan that would better facilitate access to community mental health services and supports for individuals transitioning from the correctional system into the community.

Commissioner Berry introduced Dr. Terri Timberlake, DBHDD Director of Adult Mental Health and Ms. Stephanie McClain, DOC Deputy Director of Mental Health to provide an initial report of the Transition Care Project's work.

Dr. Timberlake reported that there have been 3 meetings held since initially convening in May. The workgroup is comprised of representatives from:

- Department of Corrections
- Department of Pardons and Paroles
- Department of Juvenile Justice
- Georgia Vocational Rehabilitation Agency
- Department of Community Health
- Emory University the Fuqua Center
- Department of Behavioral Health & Developmental Disabilities *(Office of Dev. Disabilities, Housing, External Affairs, Forensic Services, Jail Diversion/Trauma Recovery Program, Child and Adolescent and Adult Mental Health).*

DISCUSSION

Stephanie McClain provided an overview of the inmate population and the number of those inmates who have a behavioral health diagnosis.

- Approximately 60,000 offenders
- 9,628 (17%) of the total population are offenders with mental illnesses
- 2,106 of the offenders with a mental health diagnosis have a serious or persistent illness and are classified by the DOC as a Level 3 or Level 4
- The DOC mental health classification levels are:
  - Level 2 = Mild impairment
  - Level 3 = Moderate impairment
  - Level 4 = Moderate to Severe impairment *(Level 3 & 4 inmates require more behavioral health inpatient care)*
- 61% (approximately 5,800) of the inmates with a mental health diagnosis are on psychotropic medications
- In May, a little over 758 of the population with a mental health diagnosis were actively on parole
- In calendar year 2012, there were 1,383 mental health offenders released on probation, parole or probation with parole to follow. This is a population that could be targeted by the work group as they are currently under supervision and are easy to track
- The maxed out population of Level 3 and Level 4 offenders and sexual offenders could benefit from housing assistance.

Dr. Terri Timberlake discussed barriers identified by the workgroup, which include:

- A lack of mental health services in rural areas;
- Linking dually diagnosed consumers with appropriate after care;
- A lack of cultural competence with trauma informed care;
- Lack of workforce that is adequately trained and skilled to support persons with trauma;
- An overall lack of knowledge of resources among agency

DISCUSSION	staff; o Medication access; o A lack of housing particularly for persons with a history substance abuse and/or a sexual offense; o Transportation for accessing services; o Stigma both within our agencies and in the community; and o The ability to link persons to appointments prior to their release. ▪ **Prioritizing the barriers** o Stigma –interagency and intra-agency *(discrimination contributes to denial of housing and the means to make a decent living)* o Capacity and access o Awareness and access to knowledge o Housing resources ▪ **Areas of exploration** o Better understanding of the Corrections, Pardons and Paroles and DJJ systems (assessment, diagnosis, treatment and pre-release planning processes; information sharing; coordination/release planning). o Better understanding of how substance abuse diagnosis and treatment is handled o Needed data - persons with mental illness after release; those on probation or on parole (tracking and monitoring) o Needed data – GCAL appointments (time it takes to get in, average length of time for an initial appointment and for doctor's appointments) o Discharge/release process – regarding 30 day medication supply and appointment with a psychiatrist. o Data process needed - to determine the number needing follow-up appointments, establish a target based on who's scheduled for discharge in 'x' time who meet mental health, substance abuse and/or co-occurring diagnoses, and project the number of appointments needed. o Knowing the net failure – where do people fall through the cracks and why? o For DOC, Probation and Parole, and DJJ – what is the failure rate or approximate % of persons for whom the lack of coordination causes the individual not to access services and/or resources needed. Similarly, what is the success rate? o Tracking stability of housed/homeless and how long o Knowledge of highest mental health level while incarcerated, not just at discharge o How many offenders have residential restrictions because of sexual status?
	Question: Stan Jones: Of the 17% or 9,628 inmates with mental illness, do those numbers include Levels 2, 3 and 4? Answer: Stephanie McClain: Yes, the 17% does include Levels 2, 3 & 4. The 2,106 reflects the number of inmates with serious and persistent mental illness. Question: Stan Jones: Of the 758 offenders on parole, does the population include offenders with a serious diagnosis of mental illness? Answer: Stephanie McClain: No, not all of the offenders in this population have a serious diagnosis.

CONCLUSIONS	DOC Commissioner Brian Owens commended the work group for their work on transition care and shared his excitement about the collaboration between agencies. Commissioner Owens also stated that Governor Nathan Deal has announced that one of his pushes for the next legislative session will be prisoner reentry. The focus will be on persons who are maxing out with no supervision. Commissioner Berry stated that he and Commissioner Owens spent a half day in Rome, Georgia meeting with representatives from the Georgia Association of Community Service Boards (CSBs) to discuss the role the CSBs play statewide in addressing some of the challenges that individuals face accessing treatment. Question: Stan Jones: Do persons coming out of prison have access to funding from the Settlement dollars? Answer: Commissioner Berry: A person coming out of the prison system can have access to services through an ACT Team; however, DBHDD would not receive the same credit for an individual who is receiving the same services and not coming from the prison system.

INTERAGENCY DIRECTORS TEAM UPDATE — MONICA PARKER, DBHDD; URSULA DAVIS, DHS

DISCUSSION

Commissioner Frank Berry introduced Monica Parker, DBHDD director of Community Mental Health and Ursula Davis, director of DHS Systems of Care.

Monica Parked shared that the Center for Disease Control (CDC) has joined the IDT Project. CDC has data and statistics regarding the population of youth with behavioral health diagnoses.

- **IDT Collaborative GOAL**
  - Children growing up to be healthy adults who live in the community, are employed, choose and guide their care, in the least restrictive environments possible.

- **SUB-GOAL 1:** Build capacity to provide optimum practice for young children with behavioral disorders (ADHD, ODD, conduct disorder). Based on analyses of 2011-2012 National Survey of Children's Health survey data, the parent-reported prevalence of current ADHD was 9.3% in Georgia, which is slightly higher than the national estimate of 8.8%. Nationally, the average parent-reported age of ADHD diagnosis among all children with ADHD was 7.0 years of age. The average parent-reported age of ADHD diagnosis among children in GA was 7.5 years of age. The average parent-reported age of diagnosis of ADHD decreased with increasing parent-reported ADHD severity (Table 1). A younger age at diagnosis is typically associated with a more severe form of ADHD, or other behavioral health diagnosis.

DISCUSSION

Ursula Davis discussed two strategies identifying current work happening now in the area of child and adolescent (C&A) behavioral health in Georgia. These strategies address both practice and procedures and the kinds of impact services are making in the lives of youth.

- **STRATEGY AREA #1: Training & Education, Services & Support**
  Identify current GA practices in this area (including assessing data / practices in each related agency)

- **STRATEGY AREA #2: Policy and Practice**
  Identify best method for incorporating identified trainings / best practices into IDT partners' policies and practices (i.e. standards, contracts, strategic plans, etc.)

Question: Stan Jones asked how do youth who are in need of BH services come into the system of care?

Answer: Monica Parker answered that there is a shared responsibility for youth who are in need of BH services. A referral for treatment can come from several agencies that include DOE, DJJ, DCH and DHS.

WORKFORCE DEVELOPMENT UPDATE BEN ROBINSON, GBOR

DISCUSSION

Commissioner Berry introduced Ben Robinson, Executive Director of Academic Affairs at The Georgia Board of Regents who presented on Work Force Development.

Ben Robinson began by providing information on workforce in the public sector.

- Public Sector Health Workforce – subject to unique pressures
  - Usual Suspects
    - MDs, RN, APRNs, and DMDs
  - Some less than usual suspects
    - Laboratory personnel
    - Therapy professions
  - Unusual settings
    - Greater legal and budget constraints
    - Public expectations
    - Heavier behavioral health focus
    - More difficult "patients"

- Context: Extensive Shortages
  - Georgia struggles with health workforce
  - Growth in demand
    - Rapid growth in population
    - Aging of population
    - Increases in capabilities of workforce
  - Supply concerns
    - Aging workforce
    - Historic short supply of key professions
    - Declines in production from academic pipeline (under correction)

- Content: Public vs. Private Sector
  - Public sector competes with private settings for trained health workforce personnel
    - Shortages of personnel mean Seller's market
    - Salary, benefits, scheduling...issues at work
    - Challenges of work in public sector contribute to difficulties

- Challenges of work in public sector at work Public sector agencies also compete with each other

- Aspects of Public Sector can inhibit growth
  - Unique aspects
    - Service oriented
    - Personnel heavy
  - Budget disconnect
    - Size of budget not reflective of service demands
    - Budgeting driven by external considerations
  - Inelastic expectations
    - Provide services as demanded regardless of budget...
  - Perverse response
    - Cut staffing
    - Downgrade credentials
    - Staff-up on lower skilled personnel
    - Push duties down the professional network
    - Pray nothing goes wrong

- Unique aspects of the Health Workforce
  - Elements of health profession legal academic and practice constraints can restrict access to these professionals
    - Licensure requirements
    - Practice constraints
    - Education
  - However, these can also provide unique ways to connect

- Results in Workforce Problems and challenges of public sector employment have produces major shortages in public sector.
  - Corrections:
    - Worsening staffing ratios in key behavioral health professions – Psychology
  - Mental Health:
    - Heavy reliance on low skilled workforce
  - Public Health
    - Oral health and laboratory personnel shortages
  - K – 12 Education
    - High impact of early health interventions difficult to access (DOE not necessarily employer)
    - Therapy personnel
    - Pediatric subspecialties
    - Vision and oral healthcare
  - Nurses in short supply across the public sector

- Goal for Public Sector
  - The right professionals
  - Doing the right job
  - For the right people
  - With the right needs

- Solutions: How to get there
  - This is not simply an HR problem
  - Many issues at work
    - Employer concerns exist – benefits, salary
    - Sector problems exist – constraints of public sector and personnel shortages
    - Pipeline problems exist
    - Peculiarities of healthcare personnel exist
- Scope of practice problems exist

	Solutions o Build internal DBHDD workforce knowledge o Strengthen the education pipeline o Create more education programs as needed (or enlarge existing ones) o Establish high quality clinical education experiences for students o Establish residency/internship/post doctoral programs/ experiences for medicine, nursing, psychology and others o Develop existing workers into needed professionals - Establish career pathways - Enhance supports (salary, stipend and supervisor) for students engaged in supervised clinical practice prior to full licensure
CONCLUSIONS	Commissioner Berry states that one of the next steps would be to establish a Workforce Development Task Force to begin the implementation of the process described by Mr. Robinson. Commissioner Reese states that he is full agreement with the decision. Commissioner Cook stated that the presentation on Workforce Development provided a lot of information and is something that the BHCC may consider looking at further down the line.
COMMISSIONER'S REPORT	COMMISSIONER FRANK BERRY
DISCUSSION	Commissioner Berry presented a brief update on the DOJ. ▪ **DOJ Update** o Recently there was a parties meeting that including a joint discussion on Behavioral Health and Developmental Disabilities. Commissioner Berry acknowledged Dr. Timberlake for her presentation to the DOJ and the work that she is leading around ACT Teams, employment and housing. o Developmental Disabilities (DD) still presents quite a challenge. DD placements continue not to be where they need to be. Deputy Commissioner Judy Fitzgerald has been meeting with a group comprised of staff from the regional offices, state offices and the independent reviewer to identify problems. Dr. Li, Assistant Commissioner for Developmental Disabilities has traveled with the independent reviewer looking at placements. o DBHDD will not meet the numbers required by the Settlement Agreement to move the number of patients from DBHDD facilities into the community by the end of 2013. The Office of the Governor has been informed and is in agreement with the Department's decision to focus on providing quality services. o The DOJ has decided that DBHDD will not face any penalty for not meeting the deadline of moving people out of its institutions.

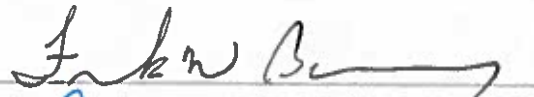
DISCUSSION	▪ **Southwestern State Hospital (SWSH) Closure and Build Up of Community-Based Services** o DBHDD is moving forward with the closure of SWSH in Thomasville, GA. o DOJ does not require us to close hospitals. However, DBHDD is required as part of the Settlement Agreement to move patients with DD diagnoses into the community. o There are nearly 600 people employed at SWSH. o Mobile crisis has been implemented in this region. o The hospital is scheduled to close December 31, 2013. ▪ **Central State Hospital Tour** o Commissioner Berry, Commissioner Cook and Commissioner Reese have toured Central State Hospital.
CONCLUSIONS	▪ Commissioner Reese and Commissioner Cook commented on the historical aspects of CSH, it housing one of the largest kitchens in the country, and it being a city within itself. ▪ Commissioner Berry thanked Commissioner Cook for his contribution to the BHCC and wished him well in his new role as Secretary of the Senate.

PUBLIC COMMENTS	
DISCUSSION	Commissioner Berry opened the floor for public comment.
CONCLUSIONS	No public comments were offered.

ADJOURNMENT	
MEETING ADJOURNED	The meeting adjourned at 11:43 AM.
SPECIAL NOTES	The next meeting of the Behavioral Health Coordinating Council will be on **Wednesday, September 25, 2013** at 10:00 AM.

RESPECTFULLY SUBMITTED BY STEPHANIE MCGRUDER

SIGNATURES

	CHAIR
	SECRETARY